

PHYSICIAN PRACTICE OPTIONS™

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Understanding the Issues Behind Practice Valuation and Sale

Physician practices are being sold at an unprecedented rate, according to Richard C. Holdren, president and CEO, of RH Medical Group, in Houston. Founded in 1981, RH Medical Group appraises and sells physician practices. Holdren likens the current consolidation among physician practices to what occurred among hospitals in the early 1970s.

"Consolidation comes in waves for different segments of the industry," Holdren says. "The latest wave involves physicians." The number of transactions among physicians, of course, could dwarf the number of transactions for hospitals.

Already, the business of assessing and selling physician practices is significant, Holdren says. Some 500,000 physicians are candidates for consolidation into larger groups and for sale to physician practice management (PPM) companies or management service organizations (MSOs), he says. Yet to date, only about 25,000 to 30,000, or 5% to 6% of the total, have been acquired or consolidated into larger companies or organizations.

Some experts predict—perhaps conservatively—that 10% to 30% of physicians will be consolidated into PPMs and MSOs in the next five years, Holdren says. The number of acquisitions announced by publicly traded PPM companies has increased dramatically in recent years. Based on year-to-date 1996 PPM acquisition activity, Townsend Frew & Co., in Durham, N.C., an investment banking firm that advises physician groups, estimates that 1996 announced transactions will total 225 to 250, approximately 2.5 times the number announced last year.

This activity has helped to drive up the valuations of PPM companies by Wall Street. The average price-to-1997 estimated net income for PPM companies is about 25 times earnings, compared with 15 times for HMOs, 16 times for hospital companies, and 13 times for long-term care providers.

Among the reasons MSOs and PPMs invest in and manage physician practices is that many physicians have soured on the hassle of running practices as managed care has come to dominate many markets. "Many physicians are not interested in running a business," Holdren says. "That's not why they went to medical school. They simply want to practice medicine."

For other physicians, selling a practice is a reward for long years of service, and a sale gives them liquidity, Holdren says. Still others find that selling their practice or an interest in it gives them access to capital, management expertise, and the ability to win managed care contracts.

Interest in Specialties

Most investors are interested in specialty practices, and lately the specialties that have generated the most interest are eye care, oncology, orthopedics, neurology, neurosurgery, urology, endocrinology, infertility, and obstetrics.

When a specialty practice is sold, Holdren says, it is generally done on the basis of cash flow. Describing a typical case, he says, "If you have a net collection of \$1 million annually, the overhead will usually be about 50%. In addition, you must hire doctors, and that costs about 30% of collections.

(Continued on page 3)

Announcing a New Forum for Readers

As many readers know, *Physician Practice Options* has a toll-free telephone number (888/457-8800) for readers seeking answers to questions involving practice options. Recognizing that when one reader asks a question, he or she likely represents many others, we will begin a new department in the newsletter titled Practice Options Q&A. In this section, we will print some of the best questions and our answers.

Here are some of the more interesting questions readers have posed to date:

I'm a solo urologist in the East, and I would like to get together with 15 other urologists to form a specialty independent practice association (IPA). What do you think?

In the short term, it's a good idea to investigate the possibility of forming an alliance with other urologists, but single-specialty IPAs have a guarded long-term prognosis. HMOs and corporate buyers don't want to deal with doctors one specialty at a time. Most payers prefer to deal with larger multi-specialty groups. They may regard a single-specialty group as a cartel. Some urologists have formed groups that specialize in lithotripter care or impotence treatment. But, to date, these groups are few in number. You may do better forming a multi-specialty group.

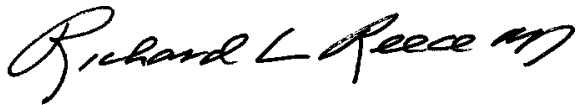
I'm a solo internist in the West who has organized a 20-member IPA. But there's a 150-member clinic in town, and the local hospital has already acquired 30 practices. What to do?

Your situation is difficult because you're late to the market. Since we don't believe it's a good idea for you to remain in your current situation, your options are: 1) align your group with the hospital; 2) be acquired by the hospital, which may be a temporary solution because most hospitals are losing money on acquired practices, and many vertically integrated systems are falling apart; 3) become a member of the 150-member clinic; or 4) move your 20-person IPA toward a tighter management service organization or an integrated group and sell your services directly to payers. The risk of the fourth option is that you would be in direct competition with the larger group. But you cannot maintain the status quo. You must take a risk or sell your practice.

As a family practitioner in a six-member group in a major southwest city, I have seen a parade of physician practice management companies intent on buying our practice. How do I appraise these opportunities and how do I find out what my practice is worth?

You need a broker who specializes in practice valuation. At least two members of our editorial Advisory Board have extensive experience valuing physician practices and would be pleased to help you. Those two members are Brooks G. O'Neil, managing director at Piper Jaffray Inc., an investment banking and securities brokerage firm, in Minneapolis, or W.L. Douglas Townsend Jr., managing director and CEO, of Townsend Frew & Co., LLC, an investment banking firm, in Durham, N.C.

We don't profess to have all the answers, but we have vast resources at our disposal and will refer you to the appropriate expert, if necessary. We invite readers to call or write me at the address below.



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Some 500,000 physicians are candidates for consolidation into larger groups. Yet to date, only about 25,000 to 30,000, or 5% to 6% of the total, have been acquired or consolidated into larger companies or organizations.

Therefore, the practice is left with about \$200,000 in net cash flow.

“Many practice management firms will pay three to six times that cash flow, or \$600,000 to \$1.2 million,” Holdren continues. “Some doctors retire and the management firm finds a replacement. About 60% of the time, the doctors continue to participate in the practice.”

When physicians continue in the practice after a sale, investors may prefer that the physicians assume some financial risk in the venture. Since they want physicians to have a financial stake in the business, the so-called Wall Street firms will rarely pay more than one-third in cash. Conversely, hospitals will pay more in cash, but hospitals prefer primary care practices, Holdren says.

While cash is one obvious advantage to be derived from any deal, the downside risk depends on the acquiring party, Holdren says. Hospitals, for example, have had problems making physician acquisitions work, and so such partnerships may lose money, he explains. “If you’ve collected cash from a hospital, all the better, but do not expect

your practice to be better as a result of an acquisition by a hospital,” Holdren says.

If your practice is bought by a publicly traded PPM, then the long-term reward may depend on how well the PPM does over time in the stock market, “although the stock of the PPMs has appreciated well.” Be certain to sell to a firm that is listed on the New York, American, or Nasdaq stock exchange, he cautions.

Another advantage of a sale is that if your practice is bought by a managed care organization (MCO), the MCO may send you

more patients. But other MCOs may stop referring patients to you. “Blue Cross, for example, may not want to send patients to a practice owned by Aetna,” Holdren explains.

Timing of the Deal

Some experts predict that the best time to sell a physician practice—whether a multi-specialty or single-specialty practice—will be within the next five years. Although the price-to-earnings ratios of PPM companies dropped last summer, Wall Street still considers the 31 publicly traded PPMs attractive and strong.

In closing, Holdren offers this advice: “Any physicians considering a sale must be valued by competent professionals. Since this is one of the most important decisions of your life, get the best advice,” he says. Townsend cautions that many physicians do not commit the time or expense to analyze thoroughly the economic implications of their options prior to selling their practice. ■

When compared with companies in other health care segments, PPMs continue to be awarded premium valuations by Wall Street. The average price-to-1997 estimated net income for PPM companies is about 25 times earnings, compared with 15 times for HMOs, 16 times for hospital companies, and 13 times for long-term care providers.

Resources

Many physicians are interested in knowing the value of their practices. This interest is being driven, in part, by physician practice management companies, which have approached physicians in markets nationwide about the prospects of selling their practices. Naturally, physicians want to know what their practices are worth from an independent source.

Independent practice brokers can help physicians determine the value of their practices. In addition, readers may be interested in working with the members of the board of editorial advisers for *Physician Practice Options* who specialize in practice valuations and in consulting to physicians. For a phone number or referral to one of our board members, please call our toll-free phone number: 888/457-8800. Readers are also invited to contact RH Medical Group, in Houston. Other sources include the following:

- **Business Valuation Resources**, Portland, Ore., which publishes a newsletter, *Business Valuation Update*. This newsletter frequently publishes the names of national independent valuation firms.
- **The Sherlock Co.**, a registered investment adviser in Gwynedd, Pa., publishes a monthly newsletter,

PPMC, containing valuation, financial, and operating statistics on publicly traded physician practice management companies.

Other sources include advertising sections of major medical journals where practice brokers advertise, and most health care consultants.

Studying Changes at the Community Level

Editor's Note: With this issue, Physician Practice Options begins focusing on changes in the health care system at the community level and will be reporting periodically on the work of the Center for Studying Health System Change, in Washington, D.C. We believe that when physicians understand how markets are changing, they respond more effectively to shifting demands from purchasers, patients, and other providers. The following article describes the center's work and is reprinted with permission from the Center for Studying Health System Change.

Recognizing that health care delivery is predominantly local, the Center for Studying Health System Change is investigating what is happening in health care financing and delivery at the community level. The center's Community Tracking Study focuses on changes in the health care system in 60 sites representative of

the nation. Twelve of these communities are being studied intensively. The 48 remaining communities studied less intensively will permit generalization to the nation as a whole and analysis of the relationship between health system characteristics and the effects of change on people. Data collection and analysis for the study are planned in two-year cycles. The first cycle, which began this year, will establish a baseline.

Three Questions

The study is funded by The Robert Wood Johnson Foundation, in Princeton, N.J., and is designed to answer three broad questions:

1. How is organization of the health system changing? More specifically, how are the organizational relationships among health plans, physicians, hospitals, and other providers being recast?

How are these organizations being affected by and responding to changes in market structure? What role do employers, consumers, and public policy play in driving changes in the health care system?

2. How do these changes affect people? That is, how are outcomes, such as insurance coverage, access to care, use of services, health care cost, quality, and satisfaction, changing over time? How do these changes differ across communities and population subgroups?
3. How are health system changes related to differences in outcomes? From a qualitative and quantitative perspective, what is the relationship between health systems and insurance coverage, access, service delivery, cost, and quality?

Focusing on communities is central to the design of the study. Health care delivery

Tracking Changes in Outcomes

Researchers from the Center for Studying Health System Change will track changes in specific areas in each of the markets studied, including insurance coverage, access, service delivery, cost, and quality by using data from the household, physician, and employer surveys. Specifically, researchers will analyze the following:

- **Insurance Coverage.** Respondents to the household survey will be asked whether they are covered by insurance and, if covered, about certain attributes of their coverage. For example, do they have to use doctors from a defined list? Can they use other doctors without incurring an extra charge? Additional data on insurance—whether employers offer insurance and what kind of products they offer—will come from the employer survey. From this information, center researchers can estimate and track over time the percentage of the population that is insured and uninsured, and key characteristics of the insurance plans of those with coverage.
- **Access.** The household survey will provide insights into traditional indicators of access, such as ease and convenience of obtaining health care services. From the physician survey, researchers will learn how readily physicians can refer patients to specialists, whether they accept Medicaid patients, and the amount of charity care they provide. Hospital discharge records also will be used to track access to health care services. For example, a high rate of hospital admissions for asthma can be used as an indicator of poor access to primary care.
- **Service Delivery.** Of all the changes taking place in the

health system, changes in the delivery of care are the ones most likely to affect people. The household survey will help track changes in how many times respondents see a doctor and the type of health services they get. The physician survey will provide indicators about the way medicine is practiced, including information about the scope of care provided and physicians' perceptions about the effect of managed care. Hospital discharge records will contribute to the changing picture of service delivery by providing information on rates for surgical procedures that vary widely in use by geography.

- **Cost.** Changes in cost will be studied primarily from the perspective of payers. Data about premiums for private insurance and employees' share of premiums will come from the employer survey, and information about out-of-pocket expenses will come from the household survey. Premiums will be tracked by type of insurance, which will permit researchers to study the extent to which changes in overall premiums are due to shifts among types of insurance. Per capita Medicaid and Medicare expenditures will come from government data.
- **Quality.** The household survey will provide answers to the personal side of quality of care: how satisfied are people with the care, what kind of preventive services do they get, and how do they rate their health status. The physician survey will collect physicians' perceptions of their ability to provide quality care. Other quality measures will come from hospital discharge records, including rates of fetal deaths, newborns with serious health conditions, and post-surgical complications.

differs from community to community for many reasons, including history, culture, and state policy. Collecting and analyzing information at the local level is critical to understanding institutional changes in the delivery system and their effects on people.

Two categories of communities have been selected for study through a process of stratified random selection. Taken together, they will provide a representative profile of change across the United States. Twelve communities will be studied in depth: Boston, Cleveland, Greenville, S.C., Indianapolis, Lansing, Mich., Little Rock, Ark., Miami, Newark, N.J., Orange County, Calif., Phoenix, Seattle, and Syracuse. Intensive case studies will be conducted in these communities and sample sizes for surveys will be large enough to draw conclusions about health system change for each community.

Data Sources

Data for the study will be collected from a variety of sources. Center staff and others will conduct site visits to gather qualitative information from the major components of the health care system, including purchasers, state governments, health plans and insurers, hospitals, physician organizations, community health centers, public health departments, and consumer organizations. The site visits will provide a rich understanding of health system change and will help in interpreting quantitative data.

Much of the information on the effects of health system change on people will come from the surveys of households and physicians that the center developed and is directing. The household survey will involve obtaining information about access to care, how individuals enter the health system, use of care, financial burdens, satisfaction with care, selected indicators of quality, and attitudes that predict demand for insurance. Respondents will be asked for the name of their insurance plan. In turn, health insurers will be asked to provide characteristics of that plan.

The physician survey will provide an additional perspective on changes in care provided to patients. Practice styles will be evaluated through clinical vignettes to assess physicians' decision making concerning use of discretionary procedures and referrals. The center will measure physicians' perceptions of their ability to meet patients' needs and expectations, including technical quality and clinical autonomy.

Finally, the center will commission surveys of a number of health system organizations. These surveys will build on information collected during the site visits, permitting more depth and objectivity on selected issues and more breadth through a larger sample of respondents. Organization surveys and secondary data will be the source of information about organization of the health system in the 48 less intensively studied communities. Surveys of hospitals, physician groups, and health plans and insurers will be developed and fielded. The center will gather information on health insurance premiums, types of health plans offered, and employer strategies for purchasing health care coverage from an employer survey.

For more information, contact the center at:
Center for Studying Health System Change
600 Maryland Avenue SW Suite 550
Washington, DC 20024-2512 ■

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Keys to Developing Successful Physician-Hospital Organizations



Nathan Kaufman is the founder of The Kaufman Group, in San Diego, a consulting firm that works with physicians, hospitals, and other providers to form health care organizations and to develop managed care strategies.

A member of the editorial Advisory Board of Physician Practice Options, Kaufman is the lead faculty member of the course, Advanced Managed Care and Integration Strategies, sponsored by the American College of Healthcare Executives, in Chicago. He is the primary author of Building Business Relationships with Physicians, (American Academy of Family Physicians, Kansas City, Kan., 1995). This interview was conducted by Richard L. Reece, MD, editor-in-chief.

Q: Nathan, could we begin by having you tell us about your organization in San Diego?

A: The Kaufman Group is five years old and our primary focus is group practice formation and integrated delivery system formation. The majority of our work is with hospital-affiliated group practices. In addition, we have developed equity-model management service organizations (MSOs) with doctors and hospitals. We have valued more than 500 physician practices and have developed delivery systems in a number of major markets. That's basically our niche. Because we are based in California, we've worked on a number of medical group affiliations and transactions. Since we've seen the actual operations and financials of these integrated delivery systems and medical groups, we can differentiate between what's fact and what's fiction.

Q: Do you have many models of successful hospital group practice integration?

A: We hesitate to say whether they're successful or not because the models that we have are two-, maybe three-years old. Most of the models that we have seen to be working reasonably well, that is, the

physicians are generally happy with the situation, they seem to feel that they're better off, and the hospitals in general feel that in the aggregate they're better off. So from that standpoint yes, we've been successful but it's too early to tell.

Q: As you know, much has been written about the tensions and the inherent conflicts between hospitals and physicians. How do you resolve those tensions or how do you deal with them?

A: The first objective is to try to ensure that the physicians are self-governing. Even in situations where the hospital puts the doctors on salary, we're still creating medical group structure. We believe that doctors have to be allowed to govern themselves because they don't feel comfortable as hospital employees.

Next, we try to create an environment where the hospital and physician incentives are aligned economically. This is important because if the hospital provides the physicians with a bad deal, the physicians will feel disenfranchised and eventually leave or stop working. Conversely, if the doctors

together. The problem is that when you try to take an egalitarian approach, that is that all physicians be treated equally, and have a goal that the physicians and hospitals should ultimately benefit or be better off than they are today, you find that those are unrealistic expectations. Instead, we believe that if primary care physicians want to be successful in managed care and in reducing the cost of care, then they must be committed to reducing the use of hospitals and specialists. If they are committed to this philosophy, then the primary care physicians must have a governing structure whereby the specialists cannot out-vote them when it's time to begin to manage care tightly. Under managed care, the premium has to be redistributed such that the hospitals and the specialists are going to take about a 30% hit. Very few egalitarian medical staff-based organizations have the discipline or willingness to have the specialists volunteer to take a 30% cut in pay.

Q: So that the primary care doctors would receive a 10% benefit?

“Even in situations where the hospital puts the doctors on salary, we still believe that doctors have to be allowed to govern themselves because they don't feel comfortable as hospital employees.”

give the hospital a bad deal, the hospitals will eventually be bankrupt and have to be sold. So the key to success is really on the front end, structuring the contract so there's economic alignment and giving the physicians the maximum amount of autonomy.

Q: You've said that most physician-hospital organizations (PHOs) are dysfunctional. And you've given some criteria for successful HMOs, but you point out that most successful PHOs don't meet those HMO criteria. What are the criteria for a successful PHO?

A: First of all, we believe that physicians and hospitals should work

A: Yes, possibly a 10% benefit. No one gets rich under managed care. In managed care, the premium goes down. There's less money. The primary care physicians receive the same, or perhaps benefit by 5%, 10%, or even 15% in a very good case, while the specialists usually take a 30% hit, because savings are derived from reducing the use of specialists and hospitals. The only ones who really benefit in this type of model are the payers, such as MCOs, who are able to capture more of the premium dollar. PHOs have very little negotiating clout against payers who don't recognize

them as a contracting entity. Because of antitrust laws, the PHO can't boycott the payer, and as a result the PHO is used only when the payer chooses to do so.

Q: *So under the best of circumstances the PHO causes redistribution of the health care dollar or reallocation of resources?*

A: If structured correctly, the PHO will be attractive to some payers. Under the best circumstances, payers will say, "These doctors and hospitals understand what we're trying to do here in managed care. They will be the ones to redistribute the premium. As the payer, we don't need to be in the middle, and we can use this delivery system as a partner in our goal of capturing more market share." That's the best-case scenario, but in order for the payer to do that, they have to feel comfortable that the PHO is not going to try to steal their business in three to five years and contract directly with the employer. They also have to believe that when the PHO receives only \$80 in premium per member per month (PMPM), or even \$72 in premium, that their delivery system won't go bankrupt.

Q: *Let's talk about negotiating power for a bit. What gives a group negotiating power?*

A: Well, there are basically two factors. Number one, if you're a sole community hospital, you have a lot of negotiating power. Physicians that are affiliated in PHOs with a sole community hospital have the potential of gaining the market power of that sole community provider. And we've seen that. The second thing that gives power to an integrated delivery system is primary care physicians in a fully integrated group practice, or what I like to call the biggest, best medical group in the market. This type of group can basically contract as a single unit and agree to take a contract or turn down a contract. If the biggest, best medical group in the market, having many primary care physicians among its member physicians, decides to turn down a contract en masse, then the payer must find new

gatekeepers for all of those patients. Gatekeepers are in short supply, especially really good ones, and the payers may find themselves unable to sell the premium because the biggest, best medical group in

into personal computers, for example, because they were concerned about the impact of personal computer sales on mini-computers. Apple, on the other hand, was not concerned about mini-computers and

"Under managed care, the premium has to be redistributed such that the hospitals and the specialists are going to take about a 30% hit. Very few egalitarian medical staff-based organizations have the discipline or willingness to have the specialists volunteer to take a 30% cut in pay."

the market isn't a participating provider. Therefore, I believe that group negotiating power is strongest with a large primary care-based multi-specialty group practice together with a sole community hospital.

Q: *Many of the readers of this newsletter are in Stage 2 markets with 10% to 30% HMO market penetration. Realistically, what are their best options in these evolving markets with currently fairly low penetration?*

A: I think one of the most dangerous things we've done in health care is that we've partitioned managed care penetration into very nice orderly stages, so that you'd expect that after Stage 2 comes Stage 3. Well, in many markets, after Stage 2 comes Stage 6. As a result, you cannot assume that your market is going to go through an orderly, timely transition from one stage to the next. If you were a market leader in the old fee-for-service system, and you want to be a market leader today in the new managed care system, you need to form the right group now rather than transitioning into a strategy gradually. If you study other industries, what you'll find is that the people who are successful when there's a structural change in an industry are the people who leap into the new environment, not the people who try to transition into it. IBM did not lead the charge

so they jumped into the personal computer market with both feet and were able to dominate the market for a while. The point is this: physicians should not look at transitional strategies but should very quickly say, 'How can we avoid becoming a commodity? How can we differentiate ourselves from everyone else?' The only way I know to do that is to create the biggest, best medical group in the market.

Q: *So you advise physicians to take the leap and go directly to a large integrated group practice?*

A: Yes, that's my opinion.

Q: *Should the group have a sizable market presence, 20% or so, in any given market it? Should it have a critical mass?*

A: It should have a critical mass and its goal should not be to benefit the individuals. Many group practices fail because the group is structured for the benefit of the individuals. The purpose should be to create the best medical group in the market and decisions should be made based on what is best for the group.

Q: *What do you think about the new phenomena on the horizon which some people call the 'Wall Street Phenomena,' where physicians are consolidating into practice management companies?* (Continued on page 8)

“Physicians should not look at transitional strategies but should very quickly say, ‘How can we avoid becoming a commodity? How can we differentiate ourselves from everyone else?’ The only way I know to do that is to create the biggest, best medical group in the market.”

A. Well, the reason that those practice management companies have developed is because there has been a need for professional management in the physician group practice arena. The hospitals have historically taken a kind of half-hearted approach to this, viewing it as an ancillary business of the hospital. And to be honest, most hospitals have failed, and hopefully are learning from their mistakes. These practice management companies saw a need, and because this is their sole function, many of them do a better job of managing physician practices than either physicians or the local hospital. Wall Street sees that there are perhaps 8,000 to 10,000 doctors currently consolidated in these groups, but there are 200,000 to 300,000 doctors in the market, and so these groups have the potential to grow enormously. Wall Street is rewarding practice management companies with the most potential for growth with stock prices that are very high multiples of earnings.

Q. *What advantages do physician practice management (PPM) companies have over hospitals?*

A. One advantage that they have over hospitals is that physician management companies can raise capital on Wall Street and they're able to negotiate deals that align the incentives more at the medical group level. In other words, it's easier for physician management companies to go to a doctor, or to a medical group and say, 'We're going to give you a good price for your practice, but you'll receive reduced compensa-

tion because you'll keep a lower percentage of profits, and you'll need to share the risk with us.' However, to return to the same level of compensation, the physician can simply increase the size of his or her practice. Whereas if a hospital expects its doctors to accept reduced compensation, the doctors will most likely protest because they are on the hospital's medical staff and have historically supported the hospital. We've found that the Wall Street firms or the physician management companies usually can create straight-forward business relationships with these medical groups, while the hospitals may have existing conflicts and incestuous historical relationships that can complicate negotiations.

Q. *Another advantage of the Wall Street firms is that they can offer an exit strategy of going public that the nonprofit hospitals can't offer. Is that true?*

A. The for-profit hospitals can bundle their physician practices, if the physicians are interested, and form a separate company. Wall Street firms can offer either cash or stock to physicians, while the nonprofit hospitals clearly don't have as many options.

Q. *Your company has worked with Columbia, the largest for-profit hospital chain in the country. Personally I regard them as a catalytic force for change. Could you articulate their strategy?*

A. I think that Columbia recognizes that a physician strategy has to be tailored to the local market and so they are developing strategies on a market-by-market basis.

They don't have a corporate cookie-cutter for relating to doctors. They look at the market, the payers, what their supporting physicians want, and try to structure a relationship that makes sense for each situation.

Q. *Do they have a management service organization (MSO) strategy?*

A. In markets where it makes sense to do an MSO, which simply runs the business side of the physician practice, they will do that. In markets where it makes sense to do some sort of joint-venture physician-group model, where ownership is shared, they'll do that. They have a number of models that they've applied to different markets.

Q. *So where is it all going? Is the California model going to sweep into the East?*

A. The California model is a mess. What's happening in California right now is that there is a commodity situation at the payer level. In other words, most of the payers are contracting with the same physician organizations and the same hospitals and so there's no differentiation among them. In order to get employers' business, what the payers are having to do is reduce their premium, and in turn they are trying to pass on those premium reductions to the providers. So it's a real mess.

Q. *How much lower can premiums go? What is the bottom of the market?*

A. They will keep going lower until the providers organize in a meaningful way to counter the payers' actions. We are now hearing from large medical groups that they will not accept any lower fees from the payers. However, many of these contracting organizations are not sufficiently integrated to say no. Also, there are situations in which primary care physicians in solo practice also belong to an independent practice association (an IPA), and the IPA decides to turn down a contract that represents 20% of that primary care physician's business. Those primary care physicians can't afford that. They need to pay the rent. So they'll have to contract with that payer some other way. Until that primary care physician is in some organization or fully integrated group where he or she can be

insulated from those kinds of market forces, we will continue to see desperate physicians taking on these contracts.

Q: *I've noticed that MedPartners, a for-profit physician management company, has not been intimidated by the maturity of the California market. Is that an example of a countervailing force?*

A: The reason MedPartners hasn't been intimidated is because they are affiliated with the largest fully integrated group practice in California, Mullikin. You can be

population.

Q: *You'll have to pardon the mixed metaphor, but some say that the modern managed care market wars are a brass knuckles fight and the brass ring is Medicare, and he who controls the Medicare population controls the market.*

A: We review the financials of many of the large medical groups on the West Coast, and we have found very few that are making any money from commercial insurance. Most of the money to be made in

fee-for-service kind of environment.

Q: *Isn't the HMO market share for Medicare already 40% to 50% in Southern California?*

A: In Southern California, in fact it is. And as I mentioned, that population is going to increase whether you're going to market directly to the Medicare recipient or through an intermediary because enrollees don't want higher co-payments.

Q: *Let's conclude by going back to the issue of specialists. If you are a 40-year-old specialist seeing this tidal wave of managed care coming up, what are your best options?*

A: Your best option is to become part of the biggest, best medical delivery system in your market, which means a large, powerful, multi-specialty group. You want to be their specialist. If it means that you and a couple of exceptionally trained colleagues can get together and create a better specialty network or specialty group practice than anybody else and that people will clearly want to use it because you're measurably better, then that's a good thing. But if you stay in solo practice or if you form large networks which include everybody, you're just repeating the PHO mistakes of the past. The question the specialists have to ask when all is said and done is 'How are

"If you study other industries, what you'll find is that the people who are successful when there's a structural change in an industry are the people who leap into the new environment, not the people who try to transition into it."

less intimidated when you're one of the major forces in the market.

Q: *What is the future of these major market forces, of Kaiser Permanente, for example?*

A: Kaiser is unbundling their services more and more. In Southern California, in particular, there are two or three factors to consider. First, the earthquake damaged a number of Kaiser's facilities. They're wondering if they should rebuild those facilities when there are so many excess beds. Second, they are beginning to question whether they need to have employed physicians for all of the specialties they cover. Perhaps it might be possible to contract with local specialists. Finally, as they try to capture the more profitable market segment of managed care, which is Medicare, they're beginning to realize that in order to capture a large Medicare population, you need to have those Medicare patients' physicians as participating providers. Most of those physicians are not Kaiser physicians, so I think Kaiser is looking at affiliating with outside networks to capture the Medicare

mature managed care markets is in Medicare.

Q: *What about the politics? What will evolve in Washington? Are we going to have provider-sponsored organizations that are exempt from HMO regulations?*

A: I don't know, but because they're going to have to slow down the esca-

"The question the specialists have to ask is, 'How are we going to be different and better than the other specialists?' If you don't have an answer to that, you're a commodity, and you must be prepared to take lower prices in order to continue to have full-time work."

lation of Medicare expenditures, you can assume that increased patient co-payments will be required. Simply increasing co-payments will most likely force more Medicare enrollees into managed care, and in most cases specialists get paid a lot less for Medicare managed care than they do in a

we going to be different and better than the other specialists?' If you don't have an answer to that, you're a commodity, and you must be prepared to take lower prices in order to continue to have full-time work. ■
For further information call our toll-free number: 888/457-8800.

How Behavioral Health Care Risk Sharing Cuts Overall Costs

By Stephen P. Melek, FSA, MAAA



Stephen P. Melek, FSA, MAAA, is a consulting actuary with Milliman & Robertson, actuaries and health care consultants, in Denver. His areas of expertise include behavioral health care, health plan

design, pricing, capitation analysis and development, risk analysis, reimbursement analysis and strategies, profitability and experience analysis, pricing models and strategies, health care revenue distribution, and utilization management analysis. He has advised physician groups, hospitals, PHOs, HMOs, PPOs, managed care organizations, behavioral health care firms and associations, insurers, employers, and state insurance departments. He joined the firm in 1990 after 14 years of experience in health insurance, with Aon Corp., The Signature Group, and Bankers Life and Casualty Co., in Chicago. A graduate of the Illinois Institute of Technology, Melek is a Fellow of the Society of Actuaries, a Member of the American Academy of Actuaries, and a Master Fellow of the Life Office Management Association.

First of two parts

Under managed care, risk-sharing arrangements have proliferated among medical care providers, encouraging, among other things, the wellness of insured members and some corresponding cost savings. It is rare, however, to find risk-sharing arrangements among behavioral health care providers or between behavioral and medical care providers. Nonetheless, risk sharing offers significant advantages for physicians.

Financial risk sharing encourages the participating providers to work together to get people healthy, keep them healthy, and, as a result, to reduce their health care costs. These goals are accomplished by motivating health care providers to reduce or eliminate inappropriate or unnecessary facility-care days, professional services, and ancillary or miscellaneous expenses through var-

ious financial incentives. It also encourages the development of lower-cost methods of service, while maintaining and achieving high-quality health care.

An example of such a financial arrangement among medical providers is an HMO or insurer capitating a physician-hospital organization (PHO) or integrated delivery system (IDS). The PHO may use this capitation revenue to fund a risk-sharing arrangement among its medical providers

that includes:

1. An institutional or facility risk pool,
2. A specialty physician risk pool, and
3. Primary care physician (PCP) capitation.

In this example, the PHO or IDS determines separate budgeted per-member-per-month (PMPM) fees for the three providers. Behavioral health care typically is excluded from such an arrangement. The PHO puts the facility PMPM revenue into the facility risk pool and may pay facility

CASE STUDY:

Psychological Distress and Cardiac Rehabilitation

A 1993 study by Thomas G. Allison, MD, and associates at the Mayo Clinic, in Rochester, Minn., examined whether early identification and treatment of patients with psychological distress in cardiac rehabilitation can reduce rates of re-hospitalization. Previous studies had implicated psychological factors in the development of coronary artery disease and in a decreased long-term survival following myocardial infarction (MI).

To determine the early effects of psychological distress, 381 consecutive patients were given the SCL-90-R (Symptom Check List) questionnaire during the second week of cardiac rehabilitation following MI, angioplasty, or bypass surgery. Of these patients, 41 scored above the 90th percentile for normal adults on the general severity index of the SCL-90-R and were judged to be psychologically distressed.

Psychologically distressed patients were 2.44 times more likely to be re-hospitalized than non-distressed patients. The distressed patients were more apt to experience an MI or sudden death and were more likely to undergo a new angioplasty or bypass surgery during the six-month follow-up period. They were also more

prone to be readmitted for chest pain that was later determined not to be infarction-related and was not treated with angioplasty or bypass surgery.

Other identified risk factors predicting early re-hospitalization were abnormal exercise ECG, ejection fraction (a measure of the heart's pumping volume efficiency, normally measured at 67% or greater) less than 40%, not having had bypass surgery during the index event, and diabetes. When these variables were controlled for, the presence of psychological distress increased the risk of early re-hospitalization by 20%.

The total cost for re-hospitalization averaged \$8,556 for the 41 distressed patients, significantly higher than the average price tag of \$2,035 for the 340 nondistressed patients.

Thus, it appears that the early identification and treatment of patients with psychological distress in cardiac rehabilitation programs through the use of stress-reducing psychological programs would reduce re-hospitalization rates and their associated costs. This conclusion points toward the usefulness of integrating medical and behavioral treatment programs and health care delivery.

Figure: Risk Sharing Among Medical Providers in a PHO (All dollars are PMPM)

Medical revenue assumed

Facility risk pool revenue	\$35
Specialist risk pool revenue.....	35
PCP capitation	15
PHO administration	5
Total PHO capitation.....	\$90

Medical expenses assumed

Facility costs	\$31
Specialist costs.....	31
PCP costs	15
Total expenses	\$77

Note: For facility risk pool, allocate 50% to facilities, 25% to specialists, and 25% to PCPs; for specialist risk pool, allocate 50% to specialists and 50% to PCPs

Source: Milliman & Robertson, Denver, 1996.

costs out of the pool on a per-diem or per-case basis. Similarly, it puts the physician specialty PMPM revenue into the specialty risk pool and may pay specialist costs out of this pool on a fee schedule (per-service or package) basis. Rather than being paid from a pool, PCPs are capitated on a PMPM basis.

Risk sharing occurs when the risk pool balances are identified and assessed to the provider groups involved. The surpluses and deficits in the facility risk pool are typically split among the facilities, specialists, and PCPs. The surpluses and deficits in the physician specialty pool are typically split between the specialists and PCPs. This system is designed to motivate the various groups to work together to control costs and to promote wellness, which can reduce future costs. An example illustrates how a financial risk-sharing mechanism works in a well managed delivery system. (See the figure: Risk Sharing Among Medical Providers in a PHO.)

In this example, the PHO is not responsible for behavioral health care services. Both the facility and specialist risk pools generated surpluses (excess of revenue over expenses) of \$4 PMPM. The facility risk-pool surplus will be distributed as follows: \$2 PMPM will go to the facilities and \$1 PMPM each will go to the physician specialists and the PCPs. The specialist risk-

pool surplus will be distributed as follows: \$2 PMPM to the physician specialists and \$2 PMPM to the PCPs. In effect, the facilities receive a 6% bonus (\$2 surplus compared with \$31 cost reimbursement), while the specialists receive a 10% bonus (\$3 surpluses compared with \$31 cost reimbursement) and the PCPs a 20% bonus (\$3 surpluses compared with \$15 capitated revenue).

The potential for participating in these additional revenues (the risk-pool surpluses) encourages the health care providers to provide high quality care and develop wellness programs to get people healthy and keep them healthy. After all, healthy members typically consume lower levels of health care. In turn, the PHO could provide care for more members, and—it is hoped—provide high quality care to a larger number of covered lives. Poor or low-quality care could result in covered members re-entering the health care delivery system, needing additional care and incurring additional costs—perhaps with greater intensity.

Behavioral Health Care Providers

While these risk-sharing arrangements have proliferated among medical providers, PHOs, and integrated delivery systems, they have not been used among behavioral health care providers. Behavioral health care often is identified and treated differently, typically through behavioral carve-out or carve-in arrangements. The behavioral health care organization frequently is capitated on a PMPM basis with no provision for risk sharing with the medical side of health care delivery.

Even within behavioral health care, risk sharing rarely exists between the facilities and professionals. Usually, the capitated behavioral health care organization receives PMPM revenue to provide mental health and substance abuse care and attempts to profit by developing a continuum of alternative behavioral treatment services. Also, the organization will use the least restrictive, most cost-effective treatment methods available to obtain high-quality behavioral health care. Typically, such an organization will pay facilities on a per diem basis and will reimburse professionals on a discounted fee-for-service basis. But surpluses and deficits are rarely shared among the various behavioral health care providers. More important,

CASE STUDY:

Ohio Department of Alcohol and Drug Addiction Services

New Standards Inc., a consulting firm in St. Paul, Minn., is working with the Ohio Department of Alcohol and Drug Addiction Services to evaluate the cost effectiveness and outcomes of different substance abuse treatment modalities. New Standards is using a longitudinal study from 1992 to 1996 that ultimately will include 7,000 to 8,000 subjects who received publicly funded treatment during that period. The study will sample every region of Ohio and all the major treatment modalities.

As of April 1995, the study showed significant reductions in expensive medical services after treatment. In surveying 1,270 patients before they entered substance abuse treatment programs and again one year later, New Standards found a 70% drop in use of psychiatric emergency rooms, an 8% decline in hospital medical admissions, and a 6% decline in use of medical emergency rooms.

it is rare to find risk sharing between the medical and behavioral health care organizations. Failure to establish financial integration and risk sharing between behavioral and medical providers may limit the potential for medical cost offsets resulting from delivering high-quality, effective behavioral health care.

Uncertainty about the interrelationship between behavioral wellness and medical wellness has existed for some time. There is increasing evidence, however, that total wellness involves integrating behavioral and medical wellness and that the provision of effective, quality behavioral health care reduces medical costs. If the objective of integrated health care delivery systems is to reduce total costs of health care while pursuing wellness, and if there is an interrelationship between behavioral and medical wellness, financial integration and risk sharing between the behavioral and medical sides of

(Continued on page 12)

(Continued from page 11)

health care is simply logical. This integration and risk sharing would encourage co-responsibility for the type of care and treatment of individual members.

Medical Cost Offsets

Medical health care providers have disputed whether behavioral health care can reduce medical costs, a result known as medical cost offsets. Moreover, little

progress in integrating behavioral and medical health care and financial risk-sharing arrangements has been made. There are four main reasons for this failure:

1. The desire for fixed and isolated behavioral health care costs,
2. The difficulty in identifying and measuring any such medical cost offsets,
3. The subjective nature of some behavioral health care, and

4. Behavioral health care organizations already have one source of profits available through behavioral wellness: excess revenue over costs from carve out plans. Nonetheless, medical cost offsets have been studied and identified. (See case studies.) ■

Next month: How medical providers and behavioral health care organizations can develop risk-sharing arrangements.

CASE STUDY:

Malignant Melanomas

The influence of psycho-social group interventions for patients with cancer has been debated widely. Few dispute the reported beneficial effects in relation to improvements in affective distress, coping behavior, quality of life, and pain control. Some question the relationship of such psychological changes to disease parameters such as metastasis, recurrence, and survival. Several recent studies, however, suggest initial evidence that effective psychological intervention plays a role in improving physical health outcomes.

Recurrence and survival rates of patients with malignant melanoma who participated in structured psychiatric group interventions shortly after their diagnosis and initial surgical intervention were reported in an article, "Malignant Melanoma—Effects of an Early Structured Psychiatric Intervention, Coping, and Affective State on Recurrence and Survival Six Years Later," in the *Archives of General Psychiatry*, September 1993.

Malignant melanoma is a virulent form of skin cancer. It is highly curable with surgery alone if removed when the cancer is small and has not spread to lymph nodes, organs, or both. The principal risk factor for melanoma is skin type, which is genetically determined. Prognostic indicators once a malignant melanoma has developed are Breslow depth (size from top to bottom), age and sex of the patient, and the site of the tumor. Specifically, being over age 65, being male, having a Breslow depth greater than 1.5mm, and having the initial melanoma lesion on the trunk of the body all indicate a poorer prognosis.

A controlled experimental post-surgical study of the effects of a short-term (six weeks), structured psychiatric group intervention for patients with newly diagnosed malignant melanomas was designed to evaluate the potential differences in recurrence and survival rates between a control group that received no psychiatric intervention and an experimental group that participated in the group intervention. Both short-term and long-term comparisons were made between the two groups.

Data from the six-month follow-up study showed that the intervention enhanced effective coping, reduced psychological stress, and affected certain aspects of the immune system, specifically the natural killer (NK) cell subsystem, when compared with standard surgical treatment alone.

Data from the six-year follow-up study showed that the experimental group had a mortality level of only 30% of the control group, and a recurrence level of just 54% of the control group. The experimental group also experienced greater disease-free intervals than the control group. Actual medical costs incurred by each group were not measured.

A number of explanations are possible. As a result of increased knowledge and encouragement, the intervention may have fostered health habit improvements beyond the norm, specifically regarding better nutrition and exercise and sun protection, such as sun avoidance, wearing protective clothing, and using broad-spectrum sun blocks. Effective coping may have been enhanced, resulting in such outcomes as improved physician-patient partnerships, positive mental attitudes, and greater compliance with treatment and follow-up regimens. Patients may have learned to manage their stress better. By expressing their feelings freely to an understanding and sympathetic audience in groups they received a great deal of social support. Also, they had the benefit of hearing how others were dealing with the stress of the disease.

The study determined that patients with active behavioral coping abilities, whether they participated in the intervention or not, seemed to have the best outcomes. It was also apparent that positive coping behavior can be learned or enhanced. Those patients with high levels of distress and low levels of baseline coping need interventions aimed at enhancing their resources and improving their coping ability. Those with high levels of distress and high levels of coping need interventions aimed at reinforcing the importance of coping ability. These two groups are likely to be receptive to such interventions as a means of reducing stress. On the other hand, patients who minimize the importance and threat of cancer to their well-being appear to be at the greatest risk, presenting low levels of baseline distress and apparently lacking the required stimulus to use coping resources.

The study's major goals included fostering physician-patient relationships and improving the patients' abilities to use the medical system to best advantage; putting forward an alternative or independent treatment for cancer or any other disease or illness was not studied. The study supports the interrelationship of timely behavioral interventions with improved medical outcomes and reduced medical costs. Psycho-educational interventions were shown to be effective as an adjunct to standard medical care.

Selling to a Strategic Partner

By W.L. Douglas Townsend Jr. and Jill S. Frew

Second of three parts
 Last month we discussed various means by which physician groups could protect their independence by securing funds to support growth. One way physicians can protect their independence and secure funds for growth is through an affiliation with a strategic partner. Since there are other ways to protect independence and secure funding, physicians need to assess their strategic alternatives. Such an assessment involves analysis at two basic levels.

First, physicians would compare the value a group practice would realize by retaining control with the value that could be obtained by selling to a strategic partner. The group can determine the current value of a practice through financial modeling using cash flow projections based on the clinic's current business plan and its value in today's dollars. The group can determine the value of the practice if it were sold by developing pro forma statements of earnings before interest and taxes and a valuation based on multiples paid in other comparable transactions.

Second, physicians would assess the probability that the group can execute its business plan successfully and independently. The challenges in doing this analysis involve internal group politics or governance, competitive demands in the market, or a lack of administrative and management talent. The

presence of one or more of these factors discounts the viability that the clinic can remain independent.

In some instances, purchase prices offered for clinics have been so compelling that remaining independent was not in the best interest of the clinic shareholders. But with prices for clinics starting to cluster at certain levels (see Table: Purchase Prices of Physician Groups), the real reason a clinic should look to sell to a strategic partner is that the partner satisfies internal dilemmas that cannot be resolved otherwise if the clinic remained independent. Therefore, it is imperative when looking to sell to a strategic partner that the physicians understand the critical challenges facing the clinic and pick the partner most able to meet the clinic's needs.

Here are some of the areas in which strategic partners, such as physician practice management (PPM) companies, can bring value to clinics:

- Access to capital,
- Access to managed care infrastructure and expertise, and
- Administrative support.

Access to capital. The most common reason physician groups sell to a PPM or other management company is financial. Money for expansion and managed care infrastructure is sometimes difficult to find and often costly. Acquiring companies also may pro-

vide capital for information systems or physician recruiting to assist in positioning the group in its market.

Access to managed care infrastructure and expertise. Besides capital, most PPMs bring their affiliated groups access to a larger company's infrastructure, systems, and management resources. PPMs provide physician groups with increased negotiating clout with managed care companies, assistance in negotiating and implementing capitated contracts, and bring operational expertise to help develop clinical protocols to profit under capitation.

Administrative support. Most PPMs provide assistance with administrative functions, such as billing and collections, claims processing, and information technology. PPMs also provide lower costs from economies of scale and group purchasing contracts for supplies, insurance, and equipment. By centralizing certain administrative functions, physicians may gain time to focus more on practicing medicine.

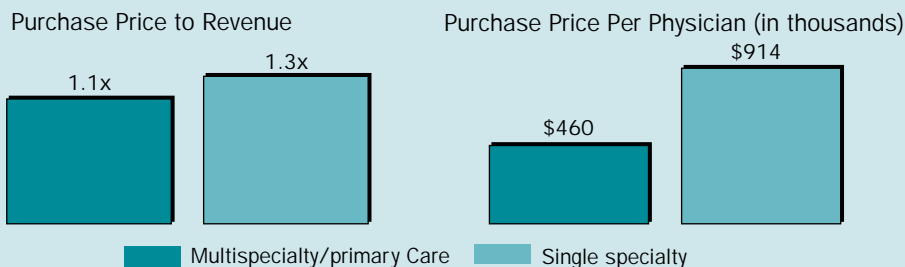
Assistance at a Cost

Such assistance comes at a cost. The group may relinquish control and, depending on how the deal is structured, may need to pay a management fee. Most PPMs receive a management fee based on a percentage (usually 10% to 20%) of the group's income after all operating expenses, excluding physician salaries. The significance of this fee is that while it aligns the incentives of the group and the management company, it puts physician income in jeopardy. In order for physicians to maintain their current salaries after such a transaction, additional revenue growth and expense reductions would be needed.

Before entering into an agreement with a PPM company it is important to be comfortable with the long-term viability and strategy of the PPM, its management team, and its integration plan for your group. Some of the best financial advisers will assist physician groups in assessing the financial implications of various strategic alternatives.

Editor's note: Next month, a discussion about combining the equity interests of multiple clinics.

Purchase Prices of Physician Groups



Note: Average multiples based on all reported transactions since January 1994 and are intended to represent multiples of group practices with three or more physicians. Revenue is last 12 months.

Source: Townsend Frew & Co., Durham, N.C., 1996.

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Jill S. Frew is managing director of Townsend Frew & Co.

Looking at Patient Satisfaction

A survey of 170,000 U.S. households in 109 metropolitan areas by the National Research Corp., in Lincoln, Neb., shows that 66.1% of respondents rated the overall quality of care and service of fee-for-service plans as excellent or very good, versus 60.2% for PPOs, and 55.6% for HMOs (Figure 1). Only 6.2% of respondents rated their FFS plans as fair or poor, versus 8.4% for PPOs, and 12.3% for HMOs. Another interesting finding: some 22.2% of respondents in Miami plan to switch health plans at the next opportunity, the highest rate among the 109 metropolitan areas. Only 10.3% of respondents in Rochester, N.Y., plan to switch plans.

Of importance to physicians are figures on the median days to an appointment. Respondents said the median wait nationwide was one day for a family practitioner (Figure 2); 10 days for an Ob/Gyn, three days for a general internist, one day for a pediatrician, and seven days for another specialist. In addition, patient satisfaction with physicians is related to physician access, National Research said. Patients who had to wait one minute or less past their scheduled appointment times reported excellent satisfaction; those who waited less than 10 minutes reported very good satisfaction; those who waited 15 minutes reported good satisfaction; those who waited 30 minutes reported fair satisfaction; and those who waited 45 minutes reported poor satisfaction. Figure 3 shows the median length of time patients wait beyond the scheduled appointment in minutes.

Figure 4 shows that satisfaction falls when patients are forced to wait past appointments. For example, 44.3% of patients rated satisfaction with wait times for family practice and general practitioners as excellent or very good, but 30.7% of patients rated wait times past appointments for family and general practice physicians as fair or poor. Figure 5 shows the percentage of households that have changed physicians. ■

Figure 1: Overall Quality of Care (By type of health plan)

Respondents rating quality as excellent or very good	
Fee-for-service.....	66.1%
PPOs	60.2%
HMOs	55.6%
Respondents rating quality as fair or poor	
Fee-for-service.....	6.2%
PPOs	8.4%
HMOs	12.3%

Figure 2: Median Days To Appointment

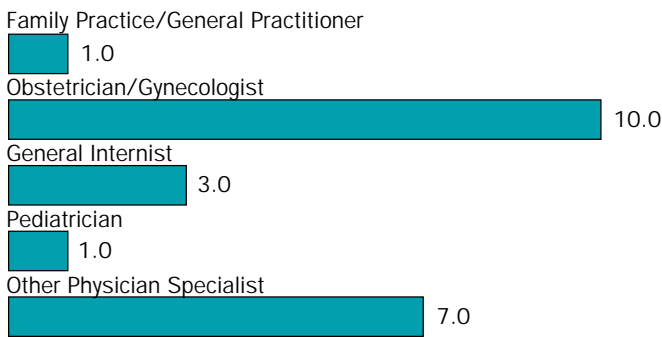


Figure 3: Median Wait Time Past Appointment (In Minutes)

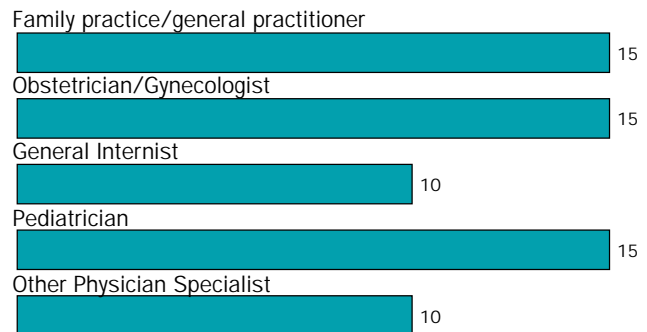


Figure 4: Satisfaction with Physician Access (By wait time past appointment)

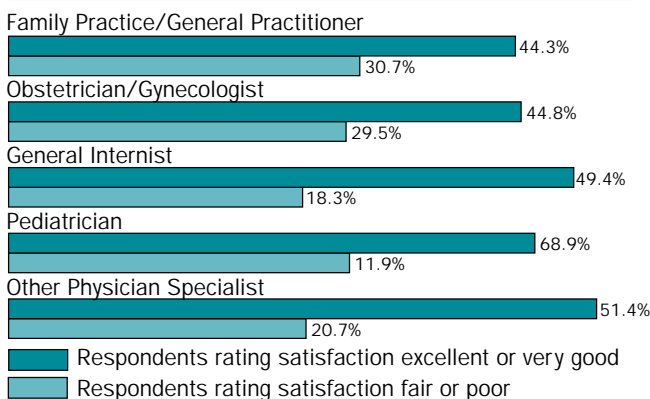
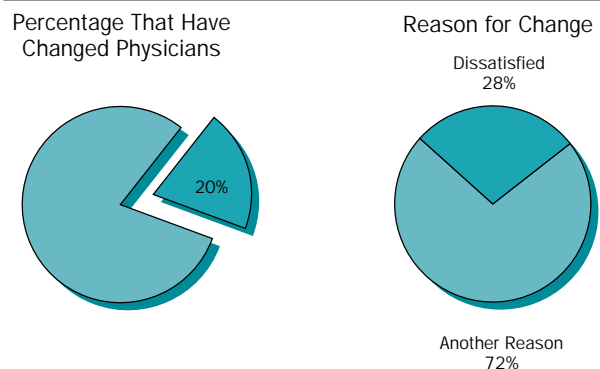


Figure 5: Percentage of Households That Have Changed Physicians in the Past 12 Months



Source (for all charts): National Research Corp., Lincoln, Neb., 1996.

Anthem Forming Large East Coast Network of Blues Plans

Blue Cross & Blue Shield of Connecticut and Anthem Inc., a large insurance holding company in Indianapolis, have agreed to merge. BCBS is Connecticut's largest managed care company, providing health care to some 850,000 residents. The company had revenue of \$1.5 billion in 1995.

With the merger, Anthem continues forming a large network of Blues plans in the

East. Anthem is consolidating Blues plans in Delaware, New Jersey, and Connecticut into Anthem East, which will have more than \$11.5 billion in annual revenue and significant market share in two regions.

Insurance commissioners in Connecticut and Indiana, as well as the policyholders of both companies, still must approve the merger, scheduled to be final early next year.

Anthem Inc. is a Fortune 500 health care management company operating in 50 states and providing health care to more than 9 million enrollees.

Comment: *Blues plans nationwide are being repositioned as for-profit entities so they can gain access to capital to compete more effectively against large managed care organizations, such as Aetna/US Healthcare.*

Two California HMO Giants Merge

Foundation Health Corp., in Rancho Cordova, Calif., and Health Systems International, in Woodland Hills, Calif., have agreed to combine in a merger valued at about \$3 billion. The new company will be called Foundation Health Systems Inc. (FHS). Both companies expect FHS's 1997 revenue to exceed \$8 billion.

Foundation and HSI expect at least \$110 million in annual operating savings to be derived from consolidating corporate overhead and administration and from merging overlapping operations, such as California HMOs. Completion of the transaction is subject to shareholder and regulatory approval and is expected by the end of January.

Comment: *Just this year, six large managed care organizations have merged: Aetna and U.S. HealthCare; PacifiCare Health Systems and FHP International Corp.; and now Foundation Health Corp. and Health System International. Purchasers fear such large HMOs will force premiums up.*

Poor, Elderly Fare Badly in HMOs

A four-year study of how HMOs care for poor and elderly people with chronic diseases shows that these patients with diabetes, depression, hypertension, and heart disease fare much worse under managed care than similar patients in fee-for-service plans.

Published Oct. 3 in *JAMA*, the study by John Ware Jr., a research psychologist at the New England Medical Center, in Boston, shows that 54% of elderly respondents in HMOs reported a decline in physical health over the course of the study, compared with only 28% of the elderly in fee-for-service plans. Some 33% of poor, ill patients in HMOs reported a decline in physical health during the study, compared with only 5% in fee-for-service plans. People under age 65 who weren't poor reported slightly better outcomes in HMOs than those in fee-for-service plans, although the difference was insignificant.

Ware called the work "an indictment of the whole notion that we are going to implement cost containment, and it's going to be just as good for everybody." He speculated that "cost containment by HMOs is being implemented in a blunt way." Spending cuts may be made wisely for many patients, but may overreach when applied to the needy, he said.

The study involved 1,574 patients in Chicago, Los Angeles, and Boston who filled out health questionnaires in 1986 and again in 1990. This self-reporting method was criticized by Susan Pisano, a spokesperson for the American Association of Health Plans, in Washington, a trade group that represents 1,000 managed care plans. Medical evaluations should have been used, Pisano said.

Comment: *The study should stun HMO supporters who claim the only way to control Medicare and Medicaid costs, now rising at 10% a year, is to direct recipients into HMOs. The government needs to develop sophisticated programs that ensure the quality of care to protect the needy and elderly.*

HMOs Report Success in Disease Management Initiatives

The latest report on HMO trends by InterStudy Publications shows that disease management programs are helping to cut costs. An organization in Minneapolis that specializes in following HMO enrollment trends, InterStudy reports that asthma and diabetes are the diseases for which the largest percentage of HMOs have implemented disease management initiatives.

Some three-quarters of the HMOs that have implemented disease management programs reported a decrease in expenditures for emergency room visits and hospital admissions as a result of the initiatives. Moreover, more than one-third of HMOs implementing disease management initiatives experienced a decline in the past year in total costs per patient in at least one disease state.

Comment: *Some 50.4% of all 630 HMOs implemented disease management programs addressing asthma, followed closely by programs for diabetes (45.5%), InterStudy said. Some 26.7% of HMOs are developing disease management programs to address congestive heart failure (CHF), but only 14.1% of HMOs actually had CHF programs in place at the beginning of this year, the report said. ■*

NEWS AND COMMENTARY

Oxford Forms Alternative-Medicine Network

Oxford Health Plans, an HMO in Norwalk, Conn., that serves patients in New York, Connecticut, and New Jersey, is building a network of 1,000 alternative-medicine providers. The network will include chiropractors, acupuncturists, naturopaths (who dispense natural-remedy medicines), and Chinese herbologists.

In building the network, Oxford is using a form of credentialing that it employs when choosing surgeons and interns. The credentialing process includes close scrutiny of applicants' educational backgrounds and visits to practitioners' offices.

A fast-growing and successful HMO, Oxford expects revenue of \$3 billion this year. Oxford has consistently been rated among the top HMOs in the highly competitive New York market in terms of patient satisfaction. Moreover, it has won significant market share in the last few years through aggressive marketing and competitive rates.

"This is less an insight of Oxford than a recognition of the obvious trend: the demand by consumers to seek an alternative to conventional Western Medical solutions," said Stephen Wiggins, chairman and CEO of Oxford. "You ignore the consumer at your own peril." Consumers spend an estimated \$50 billion on alternative medicine annually.

Patients who want access to the network of alternative-medicine providers would pay 3% more in premium and would need prior approval from their primary care physicians, just as they would when seeking care from a specialist. The network will be available next year.

Comment: *Such alternative therapies have not been widely embraced by managed care plans, although they have received some acceptance from plans in California, such as Kaiser Permanente and others. Prudential Health Plans covers acupuncture, but has not developed a network of providers.*

A Toll-free Line for Physicians 888/457-8800

Our mission at *Physician Practice Options* is to be a practical information resource for physicians seeking to thrive in health care. In a search for new practice options, physicians are asking themselves a variety of questions, including:

- Should I sell my practice?
- Should my colleagues and I form a physician organization?
- Where should I go to get capital?

We willingly make ourselves available to answer any and all such queries from readers. If we don't know the answer, we have vast resources at our disposal and will refer you to the appropriate expert.

To reach us, readers are invited to call this toll-free number: **888/457-8800**. The service is *free* to readers. Also, readers are invited to call our editors directly:

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